a. For domain measures where improvement can be measured, the improvement benchmark will be a statistically significant improvement in performance of the measure compared to the prior year's performance, where the percentage improvement over the prior year is greater than a value that can be attributed to chance. DHCF shall perform the appropriate statistical analysis to determine that performance between years is a result that cannot be attributed to chance.

b. For domain measures where attainment is measured, an FQHC must achieve the attainment benchmark of the seventy-fifth (75th) percentile for the previous measurement year to receive points for the clinical process and utilization measures. Setting the threshold at the seventy-fifth (75th) percentile means that only FQHCs performing at the level of the top quartile for the previous year would earn points for attainment. FQHCs performing below the attainment benchmark may be able to receive points if they have improved measure performance.

c. If a FQHC neither attains nor improves performance on a given measure, no points will be awarded for that measure. The total number of points for a FQHC will be the sum of the total points earned, through either attainment or improvement on a measure.

V. The annual performance percentage for each qualifying FQHC shall be calculated using the following methodology:

a. Sum points awarded for each measure in the domain to determine the domain totals;

b. Sum domain totals to determine total performance points;

c. Divide total performance points by the maximum allowed points to determine the award percentage.

VI. If participating FQHCs have aggregated beneficiaries together for determination of performance, the award percentage for the aggregated entities shall be applied to each FQHC's maximum bonus amount to determine the FQHC's performance award individually.

VII. Beginning with MY2019, and annually thereafter, performance payments shall be calculated and distributed no later than 180 calendar days after the conclusion of each measurement year once all performance measures are received and have been validated.

xiv. Rebasing for APM

A. Not later than January 1, 2018 and every three (3) years thereafter, the cost and financial data used to determine the APM rate shall be updated based upon audited cost reports that reflect costs that are two years prior to the base year and in accordance with the methodology set forth in 12.b.iii, 12.b.iv, 12.b.v, and 12.b.vi of this Section.

xv Cost Reporting and Record Maintenance

A. Each FQHC shall submit a Medicaid cost report, prepared based on the accrual basis of accounting, in accordance with Generally Accepted Accounting Principles. In addition, FQHCs are required to submit their audited financial statements and any supplemental statements as required by DHCF no later than one hundred and fifty days (150) days after the end of each FQHC's fiscal year, unless DHCF grants an extension or the FQHC discontinues participation in the Medicaid program as an FQHC. In the absence of audited financial statements, the FQHC may submit unaudited financial statements prepared by the FQHC.

B. Each FQHC shall also submit to DHCF its FQHC Medicare cost report that is filed with its respective Medicare fiscal intermediary, if submission of the Medicare cost report is required by the federal Centers for Medicare and Medicaid Services (CMS).

C. Each FQHC shall maintain adequate financial records and statistical data for proper determination of allowable costs and in support of the costs reflected on each line of the cost report. The financial records shall include the FQHC's accounting and related records including the general ledger and books of original entry, all transactions documents, statistical data, lease and rental agreements and any other original documents which pertain to the determination of costs.

D. Each FQHC shall maintain the records pertaining to each cost report for a period of not less than ten (10) years after filing of the cost report. If the records relate to a cost reporting period under audit or appeal, records shall be retained until the audit or appeal is completed.

E. DHCF reserves the right to audit the FQHC's Medicaid cost reports and financial reports at any time. DHCF may review or audit the cost reports to determine allowable costs in the base rate calculation or any rate adjustment as set forth in 12.b of this Section.

F. If a provider's cost report has not been submitted within hundred and fifty (150) days after the end of the FQHC's fiscal year as set forth in Subsection 12.b.xv.A, or within the deadline granted pursuant to an extension, DHCF reserves the right not to adjust the FQHC's APM rate or PPS rate for services as described in Sections 12.b.ii.C, 12.b.iii.G, 12.b.iv.H, 12.b.v.D and 12.b.vi.D.

G. Each FQHC shall submit to DHCF a copy of the annual HRSA Uniform Data System (UDS) report within thirty (30) calendar days of the filing.

xvi. Access to Records

A. Each FQHC shall grant full access to all records during announced and unannounced audits and reviews by DHCF personnel, representatives of the U.S. Department of Health and Human Services, and any authorized agent(s) or official(s) of the federal or District of Columbia government.

xvii. Appeals

A. For appeals of DHCF Payment Rate Calculations, Scope of Service Adjustments or Audit Adjustments for FQHCs:

I. At the conclusion of any required audit, the FQHC shall receive a Notice of Audit Findings that includes a description of each audit finding and the reason for any adjustment to allowable costs or to the payment rate.

II. An FQHC may request an administrative review of payment rate calculations, scope of service adjustments or audit adjustments. The FQHC may request administrative review within thirty (30) calendar days of receiving the Notice of Audit Findings by sending a written request for administrative review to the Office of Rates, Reimbursement and Financial Analysis, DHCF.

III. The written request for administrative review shall identify the specific audit adjustment and/or payment rate calculation to be reviewed, and include an explanation of why the FQHC views the adjustment or calculation to be in error, the requested relief, and supporting documentation.

IV. DHCF shall mail a formal response to the FQHC not later than sixty (60) calendar days from the date of receipt of the written request for administrative review.

V. Within thirty (30) calendar days of receipt of DHCF's written determination relative to the administrative review, the FQHC may appeal the determination by filing a written request for appeal with the Office of Administrative Hearings (OAH).

VI. The filing of an appeal with OAH shall not stay DHCF's action to adjust the FQHC's payment rate.

VII. Resolution of payment rate, scope of service adjustment, or audit adjustment in favor of an FQHC shall be applied consistent with the process as described below:

a. The resolution of audit findings in favor of an FQHC will be applied retroactively to the date the initial adjustment was to have taken effect;

b. The resolution of scope of service adjustments in favor of an FQHC shall be prospective only, beginning the first day of the month following resolution of the scope of services adjustment; and

c. The resolution of payment rate adjustments shall be retroactive to the date when DHCF received a completed request for administrative review.

B. For FQHC appeals of DHCF decisions on fee-for-service claims:

I. An FQHC may request a formal review of a decision made on a fee-for-service claim. To be eligible for a formal review, the FQHC must make the request within three-hundred and sixty-five (365) calendar days of receiving notice of the decision.

II. The written request for formal review shall include an explanation of the problem, the requested relief, supporting documentation and meet any additional standards DHCF or its designee may require. Written requests for formal review must be sent to the addresses provided in the DC MMIS Provider Billing Manual.

III. DHCF or its designee shall render a written decision on a request for a formal review within forty-five (45) calendar days of a completed request for review.

C. For FQHC appeals of MCO decisions on claims for reimbursement:

I. Effective July 1, 2017, for dates of services after April 1, 2017, an FQHC may request administrative reconsideration from DHCF in order to challenge an MCO's denial, nonpayment or underpayment of a claim. To be eligible for administrative reconsideration, the FQHC shall:

a. Exhaust the MCO appeal process for the MCO that issued the denial, nonpayment or underpayment; and

b. Receive a final written notice of determination (WND) from the MCO, or provide documentation that the timeframe for the MCO to render a final WND has expired without decision.

II. Requests for administrative reconsideration shall be made to DHCF in writing by mail, email, fax, or in person to DHCF's Appeals Coordinator within thirty (30) calendar days of the date of the final WND from the MCO. If no final WND was provided, the request shall be made within thirty (30) calendar days of the date that the MCO was due to render its final WND.

III. DHCF will notify the MCO when a FQHC request for administrative reconsideration has been filed to allow the MCO the opportunity to share supporting documentation.

IV DHCF reserves the right to request additional information and/or supporting documentation from the FQHC and/or the MCO, as appropriate, to assist in its determination. Failure to respond to agency requests for additional information and/or supporting documentation within the timeframe provided will not prevent DHCF from rendering a written decision.

V. DHCF shall render a written decision within forty-five (45) calendar days of receiving a complete request for administrative reconsideration.

a. If new information is provided to DHCF that warrants an extension in the amount of time it will take the agency to render a decision, the agency reserves the right to extend its review period by no more than ten (10) calendar days. The FQHC shall be notified if such an extension is required.

VI. The written decision shall constitute the final determination on the subject claim. The written decision by DHCF shall include the following minimum information:

a. Basis for decision; and

b. Supporting documentation or findings, if appropriate.

VII. If DHCF determines that the decision of the MCO was improper, then DHCF will direct the MCO to make proper payment to the provider no later than thirty (30) calendar days of its written decision. Once payment is made, the FQHC can follow protocol in making a request to DHCF for wrap payment.

VIII. If DHCF determines that the decision of the MCO was proper, but that the FQHC is still due reimbursement or payment, DHCF shall make the appropriate payment no later than thirty (30) calendar days of its written decision.

IX. If DHCF determines that the decision of the MCO was proper and the FQHC is not due reimbursement or payment, DHCF shall deny reimbursement.

DEFINITIONS

For the purposes of Section 12.b in this State Plan Amendment, the following terms and phrases shall have the meanings ascribed:

Alternative Payment Methodology - A reimbursement model other than a Prospective Payment System Rate for services furnished by an FQHC which meets the requirements set forth in Section 1902 (bb)(6) of the Social Security Act.

Capitation payment - A payment an MCO makes periodically to an FQHC on behalf of a beneficiary enrolled with the FQHC pursuant to a contract between the MCO and FQHC. In exchange for the payment, the FQHC agrees to provide or arrange for the provision of the service(s) covered under the contract regardless of whether the particular beneficiary receives services during the covered period.

Encounter - A face-to-face visit between a Medicaid beneficiary and a qualified FQHC health care professional, as described in Supplement 1 to Attachment 3.1-A, pages 37 – 40, Sections 28.B.2.b, 28.B.3.b, 28.B.4.c, and 28.B.5.c, and Supplement 1 to Attachment 3.1-B, pages 36 -39, Sections 26.B.2.b, 26.B.3.b, 26.B.4.c, 26.B.5.c, who exercises independent judgment when providing services for a Primary care, Behavioral Health service or Dental service as described under the State Plan in accordance with Section 1905(a)(2) of the Social Security Act. An encounter may also include a visit between a Medicaid beneficiary receiving healthcare services and a provider via telemedicine in accordance with District laws and rules.

FQHC look-alike - A private, charitable, tax-exempt non-profit organization or public entity that is approved by the federal Centers for Medicaid and Medicare Services and authorized to provide Federally Qualified Health Center Services.

New Provider – A FQHC that enrolls in the District's Medicaid Program after September 1, 2016 or during the time period after the rates are rebased.

Per Member Per Month (PMPM) payments – A single payment by an MCO to an FQHC to cover multiple visits.

Prospective Payment System Rate – The rate paid for services furnished in a particular fiscal year that is not dependent on actual cost experience during the same year in which the rate is in effect.

Single course of treatment – A process or sequence of services that are furnished at the same time or at the same visit.

13. Payment for Emergency Medical Care Furnished to an Alien with an Emergency Medical Condition who is not Lawfully Admitted for Permanent Residence or otherwise Permanently Residing under Color of Law

a. Emergency medical condition means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

b Payment for medical assistance under this provision shall be determined by the type of care provided and shall be in accordance with the methods and standards or reimbursements outlined in this Attachment.

14. HOSPICE CARE REIMBURSEMENT METHODOLOGY: ADULT HOSPICE

a. Reimbursement for Adult Hospice care shall be limited to the services described in Item 18 of Supplement 1 to Attachments 3.1-A and 3.1-B. The Department of Health Care Finance (DHCF) shall pay an Adult Hospice care provider at one (1) of four (4) prospective per diem rates for each day that a beneficiary is under the provider's care.

b. DHCF shall reimburse for Adult Hospice services provided to eligible beneficiaries in each election period only upon receipt of prior authorization from its designated quality improvement organization. Each election period requires a separate prior authorization.

c. Claims Submission Requirements: Claims for Adult Hospice care shall be submitted in accordance with "Timely Claims Payment – Definition of Claims," Attachment 4.19-E of the District of Columbia State Plan for Medical Assistance and procedures established by DHCF.

1. Claims that are not complete, timely, or properly prepared and submitted may be denied and returned to the provider.

2. Final claims for Adult Hospice care shall be submitted to DHCF no later than the fifteenth (15th) day of the month following the date on which any of the following occur:

i. The beneficiary dies;

ii. The beneficiary revokes the election to Adult Hospice care;

iii. The beneficiary's prognosis is no longer six (6) months or less to live; or

iv. The beneficiary chooses to change Adult Hospice providers.

d. Per diem payment rates for routine home, continuous home, general inpatient, and inpatient respite care shall be set in accordance with the amounts established for Medicare hospice providers by the Centers for Medicare and Medicaid Services (CMS), subject to the District of Columbia's wage index and any ceiling established for the Medicare program. Per diem reimbursement categories within Adult Hospice are as follows:

1. Routine Home Care: The base reimbursement category for hospice care representing any of the covered adult hospice services described in Item 18 of Supplement 1 to Attachments 3.1-A and 3.1-B that are necessary to provide palliative care to a beneficiary while the beneficiary is at home

iv. A period of crisis requires between eight (8) and twenty-four (24) hours of care, not necessarily consecutive, per twenty-four (24) hour period; and

v. The number of hours of continuous care provided during a continuous home care day shall be multiplied by the hourly rate to yield the continuous home care payment for that day.

3. General Inpatient Hospice Care: The rate category that applies for a beneficiary requiring treatment in an inpatient facility for pain control or management of acute or chronic symptoms which cannot be managed in other settings. General Inpatient Hospice Care shall be subject to the following requirements:

i. General inpatient hospice care shall only be provided on a short-term basis;

ii. General inpatient hospice care shall be discontinued once the beneficiary's symptoms are under control;

iii. General inpatient hospice care shall be provided only in the following types of health care facilities, which must meet the hospice staffing and space requirements described in 42 C.F.R. Part 418, Subparts C and D:

(a) Free standing facility owned and operated by a hospice company and staffed with hospice trained staff;

(b) Hospital; or

(c) Nursing Facility.

iv. Payments to a hospice provider for inpatient hospice care (general and respite) shall be subject to a limitation that the total number of inpatient hospice care days provided to Medicaid beneficiaries in any twelve (12) month period may not exceed twenty (20) percent of the total number of days during that period on which Medicaid beneficiaries have hospice care elections in effect.

4. Inpatient Respite Care: The rate category that applies for inpatient care provided for respite on behalf of a family member or other caregiver for a beneficiary living at home. Inpatient hospice respite care shall be subject to the following requirements:

   i. Inpatient respite care is available for beneficiaries who do not meet the criteria for general inpatient or continuous home care, and whose family members or other caregivers are in need of temporary relief from caring for the beneficiary;

   ii. Inpatient respite care shall not exceed five (5) consecutive days and shall be limited to fifteen (15) days per six (6) month period;

   iii. Inpatient respite care shall not be available for beneficiaries residing in a nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID); and

   iv. Payments to a hospice provider for inpatient hospice care (general and respite) shall be subject to a limitation that the total number of inpatient hospice care days provided to Medicaid beneficiaries in any twelve (12) month period may not exceed twenty (20) percent of the total number of days during that period on which Medicaid beneficiaries have hospice care elections in effect.

e. Physician Services

In addition to the services described in Item 18 of Supplement 1 to Attachments 3.1-A and 3.1-B, the following services performed by hospice-employed or contracted physicians are included in the per diem rate:

1. General supervisory services of the medical director; and

2. Participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the interdisciplinary group.

f. Unless provided on a volunteer basis, other physician services focused solely on direct patient care shall be paid in accordance with the D.C. Medicaid fee schedule, updated annually, and available at www.dc-medicaid.com. Payment for other physician services shall be in addition to the per diem reimbursement corresponding to the category of Adult Hospice care.

g. A beneficiary with a health condition that is completely distinct from the terminal condition for which the hospice election was made may receive other medically necessary Medicaid-covered services. These other medically necessary services shall be considered "ancillary services." Reimbursement for ancillary services shall be made in accordance with the D.C. Medicaid fee schedule.

h. When a beneficiary resides in a nursing facility or ICF/IID, the Adult Hospice provider and the nursing facility or ICF/IID shall enter into a written agreement identifying the parties' responsibilities for patient care, which shall be kept on file by both parties and made accessible for review by DHCF or its agent. The Adult Hospice provider is then entitled to receive the daily reimbursement amounts for room and board in addition to the routine home or continuous home care rates. In accordance with the terms of the written agreement between the Adult Hospice provider and nursing facility or ICF/IID, the Adult Hospice provider shall pass through the full room and board payment to the nursing facility or ICF/IID.

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15 Reimbursement Methodology for Case Management Services

1. Requests for payment of case management services shall be submitted by an approved provider according to the "Conditions of Participation" established by the State Agency.

2 The provider shall submit a request for reimbursement on claim form HCFA-1500. A separate invoice shall be submitted for each participant. Payment requests which are not properly prepared or submitted may not be processed and will be returned unpaid to the provider.

3 Clients shall be assigned to CMHS to case managers who require case management services or intensive case management services.

a. Case management services are targeted to clients who have been identified as having obtainable goals of physical survival, personal growth, community participation and recovery from or adaptation to mental illness;

b. Intensive case management services are targeted to clients who have minimal social skills for negotiating in the community and/or resist traditional forms of mental health and other treatment.

4. Payments shall be limited to one reimbursement unit per day even though the case manager may have more than one face-to-face contact with the client on the same day. This includes at least one visit to the participant's home or another suitable site at least every 90 days.

5. The reimbursement rate shall be on a fee for service basis.

a. Payment for case management services shall not exceed 50 units per year unless prior authorized.

b. Payment for intensive case management shall not exceed 100 units per year unless prior authorized.

c. Rate changes when appropriate, shall be published in the District of Columbia Register.

Reimbursement Methodology

6. The number of units shall be listed in the individual service plan. When a determination is made by CMRS that a client requires more than the upper limit of units per year, as stated in 6a and 6b, a written request including documentation supporting the medical necessity for the additional units shall be submitted to CMCF for approval.

7. Reimbursement rate for assessment or reassessment shall be on a fee for service basis. After an initial assessment the CMSH will conduct a reassessment every 180 days. The assessment and reassessment shall incorporate input from the individual, family members, friends and community service providers. Date changes, when appropriate, shall be noted in the District of Columbia's Register

8. The provider shall accept, as payment in full, the amount paid in accordance with the established fee for service.

Revision

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE District of Columbia

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Item 16 - Payment of Title XVIII Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment, if applicable, the Medicaid agency uses the following method:

	Medicare-Medicaid Individual	Medicare-Medicaid/QMB Individual	Medicare-QMB Individual
Part A Deductible	___ limited to State plan rates*	___ limited to State plan rates*	___ limited to State plan rates*
	_X_ full amount	_X_ full amount	_X_ full amount
Part A Coinsurance	___ limited to State plan rates*	___ limited to State plan rates*	___ limited to State plan rates*
	_X_ full amount	_X_ full amount	_X_ full amount
Part B Deductible	_X_ limited to State plan rates*	_X_ limited to State plan rates*	_X_ Limited to State plan rates*
	___ full amount	___ full amount	___ full amount
Part B Coinsurance	_X_ limited to State plan rates*	_X_ limited to State plan rates*	_X_ limited to State plan rates*
	___ full amount	___ full amount	___ full amount

* For those title XVIII services not otherwise covered by the title XIX State plan, the Medicaid agency has established reimbursement methodologies that are described in Attachment 4.19-B, Item(s) 17

STATE District of Columbia

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

The policy and method to be used in establishing payment rates for each type of care or services listed in §905 (a) of the Social Security Act, other than inpatient hospital care and care provided in skilled nursing and intermediate facility care, and included in the District's State Plan of Medical Assistance are described below:

17. Reimbursement and payment criteria shall be established which are designed to enlist participation of a sufficient number of providers such that services are available to eligible persons at least to the extent that such services are available to the general population.

18. Participation in the program shall be limited to providers of services who agree to accept the District's payment plus any co-payment required under the State Plan as payment in full.

19. Payments for services shall be based on reasonable allowable costs following the standards and principles applicable to the Title XVIII program. The upper limit for reimbursement shall be no higher than payments for Medicare patients on a facility-by-facility basis in accordance with 42 CFR 447.325. In no instance, however, shall charges for services provided to beneficiaries of the program exceed charges for private patients receiving care from the provider. The professional component for emergency room physicians shall continue to be included as a component of the payment to the facility.

20. Emergency Hospital Services

a. Definitions. The following terms shall have the following meaning when applied to emergency services unless the context clearly indicates otherwise:

"All inclusive" shall mean all emergency room and ancillary service charges claimed in association with the emergency room visit.

"Department" shall mean the Department of Health.

"Emergency hospital services" shall mean services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily function; or (c) serious dysfunction of any bodily organ or part.

"Recent injury" shall mean an injury that occurred less than 72 hours prior to the emergency room visit.

b. Scope. The Department shall differentiate, as determined by the attending physician's diagnosis, the kinds of care routinely rendered in the emergency room. The differentiation shall be between (1) "emergency care" as defined above under "emergency hospital services" and (2) "urgent (non-emergency) care", which does not meet the above-cited definition of "emergency hospital services". The Department publishes a list of primary diagnosis codes that meet the definition of emergency care as well as a list of primary diagnosis codes that meet the definition of urgent (or non-emergency) care.

1. The Department shall reimburse at reduced all inclusive reimbursement rate for all services rendered in emergency rooms which the Department determines were non-emergency care. For services provided in emergency rooms that do not meet the definition of emergency care on or after September 1, 1996, the all inclusive facility rate shall be fifty dollars ($50).

2. Services determined by the physician's primary diagnosis to be emergencies are reimbursed at the facility specific, all-inclusive outpatient rate described in paragraph 8 (b) of page 5 of Attachment 4.19B except that for services on or after September 1, 1996, the all-inclusive outpatient rate described in paragraph 8 (b)(4) is inflated by 40% for the purpose of reimbursing hospital emergency room services.

3. Services performed by the attending physician which may be emergency services will be manually reviewed. If these services meet certain criteria, they shall be reimbursed under the methodology for 2 above. Services not meeting these criteria shall be reimbursed under the methodology for 1 above.

NOV 27 2002
Approval Date

JAN 01 2002
Effective Date

The initial treatment for medical emergencies including indications of severe chest pains, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus, or other conditions considered to be life threatening.

ii. The initial treatment following a recent injury resulting in a need for emergency hospital services as defined in "a" above.

iii. Treatment related to an injury sustained more than 72 hours prior to the visit in which the patient's condition has deteriorated to the point of requiring medical treatment for stabilization.

iv. A visit in which the patient's condition requires immediate hospitalization or the transfer to another facility for further treatment or a visit in which the patient dies.

v. Acute vital sign changes indicating a deterioration of the patient's health requiring emergency hospital care.

vi. Severe pain would support an emergency need when combined with one or more of the other guidelines.

2k. Fee-for-Service Providers

i. The DHCF fee schedule is effective for services provided on or after the date of publication, occurring annually in January. All rates are published on the state agency's website at www.dc-medicaid.com.

ii. Except as otherwise noted in the Plan, DHCF-developed fee schedule rates are the same for both governmental and private individual practitioners.

iii. Payment for the following services shall be at lesser of the state agency fee schedule; actual charges to the general public; or, the Medicare (Title XVIII) allowance for the following services:

a. Physician's services
b. Dentist and Orthodontist's services
c. Podiatry
d. Mental health services, including community mental health services, services of licensed clinical psychologists and mental health services provided by a physician, except for mental health services listed in Supplement 2, Attachment 4.19-B, pages 1 and 1a, which shall be reimbursed based on the methodology outlined on these pages.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Medicaid services set forth below. DHCF's fee schedule rate was set as of April 1, 2021 and is effective for services provided on or after that date. All rates are published on DHCF's website at https://www.dcmedicaid.com/dcwebportal/home.

I. The DHCF fee schedule for dentist and orthodontist services, referenced at subparagraph iii.b. of paragraph 21. Fee-for-Service Providers, was set as of June 1, 2018 and is effective for services provided on or after that date.

II. The DHCF fee schedule for transportation services, referenced at subparagraph iii.l. of paragraph 21. Fee-for-Service Providers, was set as of October 1, 2018 and is effective for services provided on or after that date.

III. The DHCF fee schedule for home health services, referenced at subparagraph iii.h. of paragraph 21. Fee-for-Service Providers, was set as of July 1, 2021 and is effective for services provided on or after that date.

IV. The DHCF fee schedule for medical supplies and equipment services, referenced at subparagraph iii.i. of paragraph 21. Fee-for-Service Providers, was set as of October 1, 2020 and is effective for services provided on or after that date.

V. The DHCF fee schedule for physician services, referenced at subparagraph iii.a. of paragraph 21. Fee-for-Service Providers, was set as of December 1, 2020 and is effective for services provided on or after that date.

VI. The DHCF fee schedule for Independently Licensed Behavioral Health Practitioners, referenced at 3.1-A Independently Licensed Behavioral Health Practitioners, was set as of January 1, 2022 and is effective for services provided on or after that date.

21 (Continued) Fee for Service Providers

e. Durable medical equipment
f. Laboratory services
g Optometry services
h Home health services
i. Medical supplies and equipment
j. X-Ray services
k. Targeted case management services
l. Transportation services
m. Nurse practitioner services which include, but are not limited to, services provided by the Advanced Practice Registered Nurse, nurse midwife, nurse anesthetist, and clinical nurse specialist. The nurse practitioner may choose to be reimbursed either directly by the State Medicaid agency through an independent provider agreement or through the employing provider.

22. For Title XVIII services not covered under Title XIX in the State Plan of Medical Assistance the payment rate shall be the lower of:

a. The provider's charge for the services, or;

b. The District's fee for the service or;

c. Eighty percent (80%) of the prevailing reasonable allowable charge for the same service under Medicare at the time the service is provided.

23. Tuberculosis Related Services

a. Medically necessary tuberculosis-related services provided on an inpatient basis shall be reimbursed in accordance with provisions of 4.19A of the State Plan of Medical Assistance.

b Medically necessary tuberculosis-related services provided in an outpatient hospital department or in a free-standing clinic shall be reimbursed in accordance with the provisions of 4.19B of the State Plan Medical Assistance that refer to the appropriate provider type.

24. Personal Care Services

a. Payment for Personal Care Aide Services shall be provided at an hourly rate established by the State Medicaid Agency to be billed in fifteen (15) minute increments

b. Each Provider shall maintain adequate documentation substantiating the delivery of allowable services provided in accordance with PCA service authorization and the person's plan of care for each unit of service submitted on every claim.

c. Reimbursement will be the lesser of the amount established by the Medicaid agency or the amount charged by the provider.

d. Claims for PCA services submitted by a Provider in any period during which the person has been admitted to another health care facility shall be denied except on the day when the person is admitted or discharged.

e. The agency's fee schedule rate was set as of November 14th, 2015 and is effective for services provided on or after that date. The agency's fee schedule rate will be updated annually to reflect changes in the Medicare Home Health Agency Market Basket and changes in the District of Columbia Living Wage. All rates are published on the agency's website at www.thefdc.gov. Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published in https://www.dc-medicaid.com/dcwebportal/pages/user/FeeScheduleDownload

25. Rehabilitative Services

Mobile Community Outreach Service Teams (MCOTT)

1. MCOTT providers shall be reimbursed at a flat rate for each day on which at least one face-to-face services for the client is provided. This rate will be established by the Medicaid agency. An example follows:

Direct service yearly cost	= $1,753,700.00
Fringe Benefits & Administration (overhead which is 33% of direct service total costs)	= $578,721.00
Total Costs	= $2,332,421.00

Hypothetical number of clients = 100

Rate Calculation: ($2,332,421.00/100)/365days =$ 63.90

(this is a per person, per day rate)

2. Services must be medically necessary and prior authorized.

3 Reimbursement will not be made for services provided during a client's inpatient hospitalization.

26. Case Management Services

Target Group
This service will be reimbursed when provided to children who are Medicaid recipients age 0-20 who are either at risk of abuse or neglect or are abused or neglected children and are in the care or custody of the Children and Family Services Administration (CFSA).

An interim rate will be established. In order to ensure that such rate is reasonable for all providers, it will be based on and routinely to be bound to - the actual cost of CFSA in providing case management services to the target population. To the extent that payments will be made to governmental service providers, in accordance with Federal Office of Management and Budget Circular No. A-87 requirements, such payments shall not exceed the costs of providing such services.

These interim rates will be established for every twelve month period beginning October 1 and ending September 30th. After the actual costs for the period has been determined, all claims paid during this period will be adjusted to the actual rate. A new interim rate will be determined as described above. This will be repeated every twelve months to adjust claims paid at the interim rate to actual cost.

The Medicaid Targeted Case Management unit rate will be determined as follows:

Compute the actual cost of providing targeted case management (TCM) services through CFSA during its most recently completed twelve month period for which actual costs data exists, which includes case managers, their direct supervisory and support staff, and their indirect administrative staff. This cost includes salaries and benefits; other operating costs including travel, supplies, telephone and occupancy cost; and indirect administrative costs in accordance with Circular A-87.

Multiplied by

Percentage of time spent by CFSA Family Service Workers in performing case management work on behalf of children in the care or custody of CFSA. This percentage will be taken from the current Random Moment Time Study (RMTS), which is performed quarterly by CFSA. The RMTS is currently used to allocate worker time to various functions so as to properly allocate and claim funds from the appropriate programs.

Multiplied by

Percentage of Medicaid recipients among number of clients serviced in the month. Taken together with the RMTS percentages, this will give the percentage of the total cost of service worker time described above that is allocable to TCM.

Equals	Total cost for Medicaid Targeted Case Management Services
Divided by	12 Months
Equals	Average monthly cost of Medicaid Targeted Case Management Services
Divided by	Number of clients in receipt of Medicaid to be served during the month
Equals	Monthly cost per Medicaid eligible client for Medicaid Targeted Case Management Services. This is the monthly case management interim unit rate, which will be billed for each Medicaid recipient in the target group each month. Documentation of case management services delivered will be retained in the service worker case files.

The monthly case management interim unit rate is that amount for which the provider will bill the Medicaid Agency for one or more case management services provided to each client in receipt of Medicaid during that month. This "monthly case management unit" will be the basis for billing. A monthly case management unit is defined as the sum of case management activities that occur within the calendar month. Whether a Medicaid client receives twenty hours or two hours or less, as long as some service is performed during the month, only one unit of case management service per Medicaid client will be billed monthly.

27. Rehabilitative Services to Children Who have Been Abused or Neglected

A Rehabilitation services for children will be provided in the least restrictive setting appropriate to the child's assessed condition, plan of care and service. Services shall be provided to children in one or more of the following settings:

1. Services provided to children who reside in a family home setting will be provided either in the child's home, in the customary place of business of a qualified provider or in other settings appropriate to servicing Children's (schools, health clinics, etc.).

2. Services provided to children who reside outside of a family home will be provided in the customary place of business of a qualified provider or in an appropriately licensed and/or certified settings including:

   (a) Emergency shelter facilities licensed and/or approved by the appropriate regulatory agency in the jurisdiction within which the facility operates.

   (b) Comprehensive residential treatment facilities licensed and/or approved by the appropriate regulatory agency in the jurisdiction within which the facility operates.

   (c) Residential treatment facilities licensed and/or approved by the appropriate regulatory agency in the jurisdiction within which the facility operates, and

   (d) Therapeutic foster homes licensed and/or approved by the appropriate regulatory agency in the jurisdiction within which the facility operates.

3. Services shall not be reimbursed when provided as part of a service provided by the following facilities:

   (a) Acute, general, psychiatric or pediatric hospitals,

   (b) Nursing facilities,

   (c) Intermediate care facilities for the mentally retarded, and

   (d) Institutes for the treatment of mental diseases.

4 Rehabilitative Services to Children Who Have Been Abused or Neglected shall be reimburse through the following methods:

(a) The eight services will be reimbursed as traditional fee-for-service claims for children who are not in residential settings.

(b) Partial Day Treatment Programs providing a comprehensive treatment program including at least four of the covered services and provided at least four (4) hours per session will be reimbursed via a per diem rate which recognizes and combines each of the services actually provided in that setting.

(c) Full Day Treatment Programs providing a comprehensive treatment program including at least four of the covered services and provided at least six (6) hours per session will be reimbursed via a per diem rate which recognizes and combines each of the services actually provided in that setting.

(d) The reimbursement made in residential settings will be via a per diem rate which recognizes and combines each of the services actually provided in that setting.

5. Rehabilitative Services to Children Who Have Been Abused or Neglected shall be reimbursed through a cost based fee schedule. Documentation of the rate development methodology and fee schedule payment rates will be maintained by the Medical Assistance Administration.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

28. Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services

REIMBURSEMENT METHODOLOGY FOR SCHOOL BASED HEALTH SERVICES (SBHS)

EPSDT School based health services (SBHS) are delivered by District of Columbia Public Schools (DCPS) and Public Charter Schools (DCPCS), referred to as "providers" for Section 28.1 of this Attachment, in DCPS and DCPCS school settings within the District of Columbia.

Providers who arrange for the delivery of SBHS services by a privately owned or operated entity meeting the definition of "Nonpublic special education school or program" as defined in D.C. Official Code § 38-2561.01, are referred to as "nonpublic programs". Nonpublic programs must be certified as "Full Approval Status" schools by the Office of the State Superintendent of Education (OSSE) in accordance with D.C. Official Code § 38-2561.07 and 5-A DCMR §§ 2800 *et seq.*, and shall be used when a provider is unable to provide free and appropriate public education to the beneficiary. A nonpublic program shall submit claims for SBHS to OSSE, and OSSE shall maintain enrollment with DHCF as the SBHS nonpublic program provider of record. Reimbursement to OSSE for SBHS delivered in nonpublic programs shall be subject to cost based reimbursement.

SBHS are defined in Supplement 1, Attachment 3.1-A pages 6, 6a and 6b and include the following Medicaid services:

1. Skilled Nursing Services
2. Psychological Evaluation Services
3. Behavioral Supports (Counseling Services)
4. Orientation and Mobility Services
5. Speech-Language Pathology Services
6. Audiology Services
7. Occupational Therapy Services
8. Physical Therapy Services
9. Specialized Transportation
10. Nutrition Services

I. Cost-Based Reimbursement for District of Columbia Public Schools (DCPS) and Public Charter Schools (DCPCS)

A. Direct Medical Payment Methodology

Providers are being paid on a cost basis for SBHS provided on or after October 1, 2009. Providers will be reimbursed interim rates for SBHS direct medical services per unit of service at the lesser of the provider's billed charges or the statewide enterprise interim

rate. On an annual basis, a District-specific cost reconciliation and cost settlement for all over and under payments will be processed based on a yearly filed CMS-approved cost report.

B. Interim Payments

The units of service are defined by each Health Insurance Portability and Accountability Act (HIPAA) compliant current procedural terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code. Direct medical services may be encounter-based or in 15-minute unit increments. The interim rate is the rate for a specific service for a period that is provisional in nature, pending the completion of cost reconciliation and cost settlement for that period.

C. Data Capture for the Cost of Providing Health-Related Services

Data capture for the cost of providing health-related services will be accomplished utilizing the following data sources:

- Total direct and indirect costs, less any federal payments for these costs, will be captured utilizing the following data sources:

  a. School Based Health Services CMS-approved Cost Report received from schools
  b. Random Moment Time Study (RMTS) Activity Code 1200 (Direct Medical Services) and Activity Code 3100 (General Administration):
     i. Direct medical RMTS percentage
  c. School District specific IEP Medicaid Eligibility Rates (MER)

D. Data Sources and Cost Finding Steps

The cost report identifies SBHS costs by the following cost pools: 1) Medical costs and 2) Transportation costs. Change in the number of cost pools is determined during the CMS approval of the cost report and RMTS. The following provides a description of the data sources and steps to complete the cost finding and reconciliation:

1) Allowable Costs:

Direct costs for direct medical services include unallocated payroll and other costs that can be charged to direct medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel listed in the description of covered Medicaid services delivered by DCPS and DCPCS, excluding transportation personnel. Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as medically-related purchased services, supplies and materials. These

direct costs will be calculated on a Medicaid provider-specific level and reduced for any federal payments for these costs, resulting in adjusted direct costs. Allowable provider costs related to Direct Medical Services include: 1) Salaries; 2) Benefits; 3) Medically-related purchased or contracted services; and, 4) Medically-related supplies and materials.

The cost report contains the scope of cost and methods of cost allocation that have been approved by the CMS. Costs are obtained from the audited Trial Balance and supporting General Ledger, Journals, and source documents. They are also reported on an accrual basis.

Indirect Costs: Indirect costs are determined by applying the DCPS and DCPCS specific unrestricted indirect costs rate to their adjusted direct costs. District of Columbia Public Schools and Public Charter Schools use predetermined fixed rates for indirect costs. The District of Columbia Public Schools, Office of the Chief Financial Officer, in cooperation with the United States Department of Education (ED), developed an indirect cost plan to be used by DCPS and DCPCS. Pursuant to the authorization in 34 CFR § 75.561(b), DCPS and DCPCS approves unrestricted indirect cost rates for schools, which are also considered the cognizant agencies. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

Indirect Cost Rate:

a. Apply the District of Columbia Public Schools and Public Charter Schools Unrestricted Indirect Cost Rate (UICR) applicable for the dates of service in the rate year.
b. The DCPS and DCPCS UICR is the unrestricted indirect cost rate calculated by the District of Columbia Public Schools. Office of the Chief Financial Officer.

2) Time Study: A time study that incorporates CMS-approved methodology is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative time and all other activities to account for one hundred percent (100%) of time to assure that there is no duplicate claiming. This time study methodology will utilize one cost pool representing individuals performing Direct Medical Services. A sufficient number of personnel for the cost pool will be sampled to ensure time study results that will have a confidence level of at least ninety-five percent (95%) with a precision of plus or minus two percent (2%) overall. The Direct Medical Service time study percentage is applied against the Direct Medical Service cost pool. Results will be District-wide so every school will have the same time study percentages.

a. Direct Medical RMTS Percentage

i. Direct Medical Cost Pool: Apply the Direct Medical Service percentage from the Random Moment Time Study (Activity Code 1200). The direct medical service costs and time study results must be aligned to assure appropriate cost allocation.

b. General Administrative Percentage Allocation

i. Direct Medical Cost Pool: Apply the General Administrative time applicable to the Direct Medical Services percentage from the Random Moment Time Study (Activity Code 3100). The Direct Medical Services costs and time study results must be aligned to assure appropriate cost allocation.

3) IEP Medicaid Eligibility Rate (MER): A District-wide MER will be established that will be applied to all participating schools. When applied, this MER will discount the cost pool expenditures by the percentage of IEP Medicaid students.

The names and birthdates of students with a health-related IEP will be identified from the December 1 Count Report and matched against the Medicaid eligibility file to determine the percentage of those that are eligible for Medicaid. The numerator of the rate will be the students with an IEP that are eligible for Medicaid, and the denominator will be the total number of students with an IEP.

E. Specialized Transportation Services Payment Methodology

Providers are paid on a cost basis for effective dates of service on or after October 1, 2009. Providers will be reimbursed interim rates for SBHS Specialized Transportation services at the lesser of the provider's billed charges or the District-wide interim rate. Federal matching funds will be available for interim rates paid by the District. On an annual basis a cost reconciliation and cost settlement will be processed for all over and under payments.

Transportation to and from school may be claimed as a Medicaid service when the following conditions are met:

1) Transportation is specifically listed in the IEP as a required service;
2) The child requiring transportation in a vehicle with personnel specifically trained to serve the needs of an individual with a disability;
3) A medical service is provided on the day that specialized transportation is billed; and
4) The service billed only represents a one-way trip.

Transportation costs included on the cost report worksheet will only include those personnel and non-personnel costs associated with special education reduced by any federal payments for these costs, resulting in adjusted costs for transportation. The cost identified on the cost report includes the following:

1) Bus Drivers
2) Attendants
3) Mechanics
4) Substitute Drivers
5) Fuel
6) Repairs & Maintenance
7) Rentals
8) Contract Use Cost
9) Depreciation

The source of these costs will be the audited Trial Balance and supporting General Ledger, Journals and source documents kept at DCPS and DCPCS. Costs are reported on an accrual basis.

Special education transportation costs include those adapted for wheelchair lifts and other special modifications which are necessary to equip a school bus in order to transport children with disabilities.

F. Certification of Funds Process

Each provider certifies on an annual basis an amount equal to each interim rate times the units of service reimbursed during the previous federal fiscal quarter. In addition, each provider certifies on an annual basis through its cost report its total actual, incurred allowable costs/expenditures, including the federal share and non-federal share.

Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

G. Annual Cost Report Process

Each provider will complete an annual cost report for all school based health services delivered during the previous state fiscal year covering October 1 through September 30. The cost report is due on or before June 30 of the year following the reporting period. The primary purposes of the cost report are to:

1) Document the provider's total CMS-approved, Medicaid allowable scope of costs for delivering school based health services, including direct costs and indirect costs, based on CMS-approved cost allocation methodology procedures; and

2) Reconcile its interim payments to its total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures.

The annual SBHS Cost Report includes a certification of funds statement to be completed, certifying the provider's actual, incurred costs/expenditures. All filed annual SBHS Cost Reports are subject to a desk review by the Department of Health Care Finance (DHCF) or its designee.

H. Cost Reconciliation Process

The cost reconciliation process must be completed within fifteen (15) months of the end of the cost report submission date. The total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures are compared to the provider's Medicaid interim payments for school based health services delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in cost reconciliation.

For the purposes of cost reconciliation, the District may not modify the CMS-approved scope of costs, the CMS-approved cost allocation methodology procedures, or its CMS-approved time study for cost-reporting purposes. Any modification to the scope of cost, cost allocation methodology procedures, or time study for cost-reporting purposes requires approval from CMS prior to implementation; however, such approval does not necessarily require the submission of a new state plan amendment.

I. Cost Settlement Process

For services delivered for a period covering October 1 through September 30, the annual SBHS Cost Report is due on or before June 30 of the following year, with the cost reconciliation and settlement process completed within fifteen months of the cost report filing.

If a provider's interim payments exceed the actual, certified costs of the provider for school based health services to Medicaid beneficiaries, the provider will return an amount equal to the overpayment.

If actual certified costs of a provider for school based health services exceed the interim Medicaid payments, DHCF will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to CMS for reimbursement of that payment within 30-days of final cost settlement.

DHCF shall issue a notice of settlement that denotes the amount due to or from the provider.

If actual certified costs of a provider for school based health services exceed the interim Medicaid payments, DHCF will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to CMS for reimbursement of that payment within 30-days of final cost settlement.

DHCF shall issue a notice of settlement that denotes the amount due to or from the provider.

II. Cost-Based Reimbursement for SBHS Delivered in Nonpublic programs on Behalf of OSSE

A. General Provisions

1) In accordance with the requirements of Supplement 3 of Attachment 3.1-B, pp. 5-5b and 5-A DCMR §§ 2803.6, 2803.10, and 2814.2, DHCF will reimburse OSSE for expenditures incurred when paying for the delivery of SBHS to D.C. Medicaid enrollees covered under the Individuals with Disabilities Education Act (IDEA) who attend nonpublic special education schools that maintain "Full Approval Status" certification. Reimbursement for SBHS delivered in nonpublic programs shall be retrospective and subject to an annual cost reporting and reconciliation process.

2) Reimbursement under this Section shall be limited to payments resulting from placement in nonpublic programs, pursuant to D.C. Official Code § 38-2561.03 (Supp. 2010).

3) Reimbursement for services delivered during the course of an Extended School Year (ESY) shall not be covered.

4) Effective October 1, 2014, DC pays nonpublic providers for school based services based costs which is determined based on a reconciliation of a CMS-approved cost report. OSSE shall submit the CMS-approved cost report in accordance with (II)(B). DHCF will audit cost reports, and use nonpublic schools' invoices, described in (II)(B)(1), to tie the costs of services claimed on the cost reports. Services included on invoices must be based on services documented on each student's IEP.

B. Documentation Standards, Cost Reporting, and Record Maintenance

1) OSSE shall ensure that each nonpublic program submits all Medicaid related documentation along with each invoice which shall include costs for services delivered to a Medicaid beneficiary. Invoices submitted to OSSE must provide specific itemization of services and costs, including but not limited to the type of service, the frequency of each service, the unit of service, the total units of services, the costs of services per hour or per day, and total costs of services. Services included on invoices must be based on services

documented on each student's IEP, and must clearly identify the medical services and educational services.

2) OSSE will complete an annual cost report for all SBHS delivered during the previous District fiscal year covering October 1 through September 30. The cost report template shall be approved by CMS.

3) OSSE shall use the accrual method of accounting and prepare the cost report in accordance with the requirements of this section, generally accepted accounting principles, and program instructions.

4) The cost report is due to DHCF, or its designee, on or before June 30 of the year following the reporting period, and includes a "certification of funds statement" to be completed, certifying the OSSE's actual, incurred costs/expenditures.

5) OSSE must maintain financial records and data sufficient to support an appropriate determination of allowable costs based upon the amounts reflected in the cost report. For purposes of this section, financial records include the general ledger, books of original entry, transaction documents, statistical data, and any other original document pertaining to the determination of costs covered under this Section.

6) OSSE must maintain adequate administrative records supporting its certification of nonpublic programs and the nonpublic programs' assurances that SBHS will be delivered by qualified health care professionals determined to be licensed practitioners of the healing arts, as set forth in 42 C.F.R. §§ 440.60, 440.110, 440.130, and 440.167, the District of Columbia Health Occupations Revision Act of 1985, as amended, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3 1201.01 *et seq.*) and implementing rules.

7) OSSE must maintain the records that are pertinent to each cost report for a period of not less than seven (7) years after the date on which the cost report is filed with DHCF. If the records relate to a cost reporting period that is under currently audit or appeal, the records also must be retained until the conclusion of the audit or appeal.

8) All records and other pertinent information are subject to periodic verification and review by DHCF, or its designee.

9) All filed SBHS Cost Reports are subject to an audit or desk review by DHCF, or its designee.

C. Appeals and Reconciliation

1) At the conclusion of any required audit, OSSE shall receive an audited cost report that will include a description and the reason for each audit adjustment.

2) Within thirty (30) days of receiving the audited cost report, if OSSE disagrees with the audited cost report, then OSSE may request an administrative review of the audited cost report by sending a written request for administrative review to the Office of Rates, Reimbursement and Financial Analysis, Office of the Director, Department of Health Care Finance, 441 4th Street, NW, Suite 900 S, Washington, D.C. 20001.

3) The written request for administrative review shall include an identification of the specific audit adjustment to be reviewed, an explanation of why OSSE views the calculation to be in error, the requested relief, and supporting documentation.

4) DHCF shall mail a formal response to OSSE no later than forty-five (45) days from the date of receipt of the written request for administrative review.

D. Program Integrity

1) Reimbursement available under Section 28.II excludes room and board, tuition and other educational costs.

2) OSSE shall be prohibited from reporting expenditures that coincide with services delivered in nonpublic programs that hold probationary or provisional certification. DHCF, or its designee, shall reserve the right to request documentation to support compliance with this requirement.

3) OSSE shall not submit costs associated with Initial Psychological Evaluations pursuant to Supplement 1 of Attachment 3.1-A, pp. 6-6b and Supplement 6 of Attachment 3.1-E pp. 5-5b for SBHS eligibility under this section. The sending LEA incurs the cost of an initial Psychological Evaluation based on its obligation to place a beneficiary in an appropriate nonpublic program setting. LEAs incurring expenditures for initial Psychological Evaluations should incorporate those amounts into the RMTS methodology outlined in Section 28.I.

4) OSSE shall ensure it maintains accurate records of the National Provider Identification numbers for all SBHS rendering providers who deliver services in nonpublic programs.

5) OSSE shall ensure access to all related SBHS.

29. Other Non-Institutional Services

A. Licensed or Otherwise State-Approved Freestanding Birth Centers

1. Freestanding birth centers are reimbursed utilizing a contracted facility fee. Practitioners are reimbursed utilizing a separate professional services fee. The authority to reimburse practitioners independently can be found in Attachment 4.19B, Part 1, Section 21. Practitioners providing free standing birth center services must be licensed in the District of Columbia pursuant to the following:

(a) Physician under Chapter 46 of Title 17 of the DCMR;

(b) Pediatric nurse practitioner under Chapter 56 of Title 17 of the DCMR;

(c) Family nurse practitioner under Chapter 56 of Title 17 of the DCMR;

(d) Nurse midwife under Chapter 56 of Title 17 of the DCMR; and

(e) Lay midwife and Certified Professional Midwife under 42 CFR 440.60

Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners.

2. The birth centers shall be paid according to the District's fee schedule and any annual/periodic adjustments to the fee schedule are published on the agency's website at https://www.dcmedicaid.com/dcwebportal/home."

3. The agency's fee schedule rate was set as of January 1, 2012 and is effective for services provided on or after that date. All rates are published on the agency's website at https://www.dcmedicaid.com/dcwebportal/home.

30. Other Laboratory and X-ray Services

A. Other lab and x-ray services are defined per Supplement 1 to Attachment 3.1-A, page 4 and Supplement 1 to Attachment 3.1-B page 4, and are reimbursed based on the agency's fee schedule.

B. The agency's fee schedule rate was set as of August 1, 2015 and is effective for services provided on or after that date. All rates are published on the agency's website at www.dhcf.dc.gov. Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published in www.dc-medicaid.com.

C. To receive Medicaid reimbursement, a provider of x-ray services shall be:

(1) Licensed or registered in accordance with D.C. Official Code § 44-202 and other applicable District of Columbia laws;

(2) In compliance with manufacturer's guidelines for use and routine inspection of equipment; and

(3) Screened and enrolled as a District Medicaid provider pursuant to 29 DCMR § 9400.

D. Medical reimbursement rates for other laboratory or x-ray services are eighty percent (80%) of the rates established by Medicare, and will not exceed Medicare on a per test basis.

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates)*:

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☑	HCBS Adult Day Health
	For ADHP users enrolled in a contracted health plan, the health plan will reimburse covered services consistent with their contracts with DHCF and with the providers. DHCF's reimbursement of services through the health plan is actuarially sound and based on historic utilization of ADHP services. Reimbursement for fee-for-service adult day health services associated with the 1915(i) HCBS State Plan Option shall be paid based upon uniform per-diem rates at two acuity levels. Acuity level 1 and Acuity level 2 services shall be reimbursed in accordance with the District of Columbia Medicaid Fee Schedule. The agency's fee schedule rate will be set as of 4/1/2020 and will be effective for services provided on or after that date. All rates are published on the agency's website at https://www.dc-medicaid.com/dcwebportal/nonsecure/feeScheduleDownload. Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the DHCF Provider Web Portal available at www.dc-medicaid.com/dcwebportal/home. ADHPs will be reimbursed at two different acuity levels. To be eligible for reimbursement at acuity level 1 ADHP services, an individual shall obtain a total score of four (4) or five (5). To be eligible for reimbursement at acuity level 2 ADHP services, an individual shall obtain a total score of six (6) or higher. The specific acuity level does not affect the benefit package received by an individual. ADHP consists of one set of services that are available to all participants, regardless of acuity level. Each participant will receive services based upon their strength, preferences and health care needs as reflected by their level of need and person-centered service plan. Recognizing that some participants may have more complex needs (such as a greater need for supervision or support), DHCF has developed two reimbursement rates – one for those who meet the threshold eligibility criteria based upon their assessed needs and the other, for those whose assessed needs are higher. The enhanced rates recognize that staffing levels must increase when participants have higher acuity levels.

Adult Day Health providers are defined in this Attachment. Reimbursement for adult day health services is paid using two bundled per-diem rates that are reasonable and adequate to meet the costs incurred by an efficient and economically prudent provider. The bundled per-diem rate consists of staffing costs in addition to program materials, indirect costs, and administrative costs. Room and board are excluded in the per-diem rates.

The per diem rates are binding rates; the District will pay each provider a fixed per-diem rate. The District will pay the lesser of the per-diem rate or the amount billed by a provider in accordance with standard Medicaid payment methodology. The staffing structure used to develop the rates were tied to the program requirements and is sufficient to allow providers to meet all program requirements, but they are not bound to adhere to the wages or benefit rates included in the rate model beyond compliance with existing federal and District laws (such as our living wage laws) and the program requirements outlined in the SPA. The agency's per diem rates will be effective on the date of approval, for any services provided on or after that date. Except as otherwise noted in the Plan, State developed per-diem rates are the same for both governmental and private individual practitioners and will be published via transmittal available at https://www.dc- medicaid.com.

Staffing, wages, and benefits

The model incorporates five principle types of employees to ensure adequate staffing to meet beneficiary needs and program requirements. These include direct support personnel (DSP) providing hands-on support and care; social services professionals delivering services and programming; a program director; a registered nurse (RN); and a medical director. The cost of each of these staff types was estimated as a function of five data points: (1) the base wage or salary required to recruit and retain qualified staff and to meet District living wage law; (2) the hour paid staff would be on-duty at the program, as well as hours for paid leave; (3) the ratio of each staff member to beneficiaries attending the program; (4) the number of days in a fiscal year a program would reasonably be operating; and (5) the additional cost of providing employee benefits such as health insurance or other fringe benefits as appropriate.

Information about these five data points and how they were determined for each of the five staffing types are shown in the table below.

	Base wage or salary	Hours on duty per fiscal year	Ratio of staff member to beneficiaries	Number of operating days	Marginal addition for fringe benefits

Direct support personnel	Based on DC Living Wage	2080 (FTE) plus 80 hours paid leave	1:10 in Acuity 1; 1:4 in Acuity 2	260 (fiscal year, excluding weekends)	20%
Social services personne l	Based on competitive wages in DC	2080 (FTE) plus 80 hours paid leave	1:20	260 (fiscal year, excluding weekends)	20%
Program director	Based on competitive wages in DC	2080 (FTE) plus 80 hours paid leave	1:40	260 (fiscal year, excluding weekends)	20%
Registered nurse	Based on competitive wages in DC	2080 (FTE) plus 80 hours paid leave	1:40	260 (fiscal year, excluding weekends)	20%
Medical director	Based on competitive wages in DC	520 (0.25 FTE)	1:40	260 (fiscal year, excluding weekends)	No benefits

These data were used to calculate annual total and per-beneficiary costs for each staffing type, which was further refined into a per-diem, per-beneficiary staffing cost.

These costs are used to develop a fee for service rate and are not a part of a CMS approved methodology to identify costs eligible for certification.

Program materials, indirect costs, and administrative costs

In addition to the staffing component, the rate includes additional funding for program materials, supplies, and indirect costs, including: (1) programming supplies; (2) food and snack costs; (3) indirect costs such as rental and building maintenance costs, utilities, telecommunications, and transportation; and (4) staff training and quality management. The estimate of these costs were based in part on qualitative data collection conducted in meetings, site visits, and phone calls with existing District health care providers, and in part on similar cost categories as reported by existing District provides via cost reporting. Annualized costs were translated into per-diem, per-

beneficiary rates using an expected operating year of 260 days and expected program size of 40 beneficiaries.

After summing the staffing component and the program and indirect costs, an additional 13% was added to the rate to reflect administrative costs. The District uses this rate for other provider types and it was used here for consistency.

Lastly, the rate was adjusted to reflect attendance rates; effectively, the rate was increased slightly to accommodate continued operating costs each day a provider is open for business, despite its complete census not attending every day.

Service Limitations

ADHP services shall not be provided to persons who reside in institutions. Providers cannot bill for services that are provided for more than five (5) days per week and for more than eight (8) hours per day. Additionally, providers will not be reimbursed for ADHP services if the participant is receiving the following services concurrently (i.e., during the same hours on the date of service):

(a) Day Habilitation and Individualized Day Supports under the 1915(c) Waiver for Individuals with Intellectual and Developmental Disabilities (ID/DD);
(b) Intensive day treatment or day treatment mental health rehabilitative services (MHRS);
(c) Personal Care Aide services; (State Plan and 1915(c) waivers), or
(d) Services funded by the Older Americans Act of 1965, Title IV, Public Law 89-73, 79 Stat. 218, as amended; Public Law 97-115, 95 Stat. 1595; Public Law 98-459, 98 Stat. 1767; Public Law 100-175; Public Law 100-628, 42 U.S.C. 3031-3037b; Public Law 102-375; Public Law 106-501.

A provider will also not be reimbursed for ADHP services if the participant is receiving intensive day treatment mental health rehabilitation services during a twenty-four (24) period that immediately precedes or follows the receipt of ADHP services, to ensure that the participant is receiving services in the setting most appropriate to his/her clinical needs.

☐ HCBS Habilitation

☐ HCBS Respite Care

For Individuals with Chronic Mental Illness, the following services:

☐ HCBS Day Treatment or Other Partial Hospitalization Services

☐ HCBS Psychosocial Rehabilitation

	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☐	Other Services (specify below)	